BEFORE THE SENATE COMMITTEE ON AGING

TESTIMONY OF JEANETTE G. GARRISON

- STATEMENT OF INTRODUCTION

  My name is Jeanette Garrison. I am a nurse by training. I am married to Joseph Garrison, a now retired anesthesiologist. We met, worked, were married and raised our family near Augusta, Georgia. I was the Chair of the Board and President of Healthmaster, Inc., a Medicare paid home health care company. I also am a convicted felon. I pleaded guilty in July 1995 to ten (10) counts of Medicare fraud. My company and I have repaid the federal and state government sixteen million five hundred thousand dollars ($16,500,000.). I currently am serving a thirty-three (33) month sentence in a federal prison. I am before you today because I truly believe home health care is important, I know that by my actions I abused the system, I am sorry for what I have done, and I would like to help fix the system so that people can continue to receive home health care.

  - BACKGROUND FOR THE CREATION OF HEALTHMASTER

    During the mid-1970s we had in our family two elderly relatives who needed care. One was not sick enough to justify putting her in a nursing home but was not well enough to take care of all her own needs. The other was too sick to be in a nursing home but did not need to be in a hospital. I searched all over the Augusta area looking for services that would provide home health care to these elderly relatives. I could not find anyone who would provide the kind of services these elderly relatives needed in their homes. With my nursing background I found myself being their home health care provider.

    Frustrated with the lack of a home nursing service in Augusta, I decided to start one. With the support of Dr. Garrison, in 1976 I started what was then known as Health Help Services. Health Help Services was a non-profit company that initially had me as its only employee and a tiny office with a single chair, a folding table, and a telephone. In 1977 I began providing to others the home nursing services that I had been providing to our relatives.

    It was not long before I had a group of patients and a full schedule of home nursing visits. I then hired another nurse (who, by the way, still works at the successor to Healthmaster), and she built up a full patient load. When each of us had a full load, we added another nurse, and so on. In our first full year of operations, 1978, Health Help Services had 325 patients and made over 7,600 visits.

    Health Help Services continued to grow very quickly, both by internal growth and later by acquiring other home health care agencies. By the mid-1980s Health Help Services had eight (8) agencies in three (3) states and was providing several hundred thousand visits to patients. We had grown from just having nurses and an office manager to having lawyers, accountants, and reimbursement specialists on our payroll. Working with our advisors, we made the decision to convert Health Help Services to a for-profit company. The new for-profit company was named Healthmaster.

Healthmaster continued to grow at a rapid pace. [CHART] By 1994, the last full year in which I was involved with Healthmaster, it had twenty-two (22) agencies and one hundred (100) branch offices in five (5) states. Approximately two million (2,000,000) visits were made by the two thousand seven hundred (2,700) employees. Revenues were around one hundred million dollars ($100,000,000). Payroll alone every two weeks was around one million eight hundred thousand ($1,800,000), which was more than the total revenues Health Help Services had back in 1978.

- THE CREATION OF A COMPLEX GROUP OF BUSINESSES

A home health care company does not exist in a vacuum. It needs offices out of which to operate. It must have a source of medical supplies. Patients need medical equipment. A pharmacy must provide prescription drugs. Employees must be provided health insurance coverage for their own needs. All of this must be done in accordance with regulatory requirements imposed by each individual state and by the federal government.

It also is true that because Medicare is on a cost-based system, the home health care agency itself is not going to be a big money maker for the owner. The owner can receive a very good income -- I myself received at the end three hundred thousand dollars ($300,000) a year in salary -- but, because of the reimbursement system, there is not much equity in the home health care business itself. Instead, a large home health care agency owner can earn the biggest return from the supporting companies. This is what we did with Healthmaster.

As I told you, I am a nurse. The professionals I hired -- the lawyers, accountants and reimbursement specialists -- showed me how to create wealth through providing the supporting services.

We created a real estate limited partnership to buy office space and then rent it to Healthmaster. We created a pharmacy. An equipment and supply business was established to serve the specific needs of Healthmaster's nurses and patients. A health maintenance organization was formed and was made available to employees with Healthmaster paying the premiums. All of these steps were legitimate on the surface and created wealth for me as an owner, and if properly monitored and reported, created no problems. Indeed, because these steps, if legitimately pursued, actually brought down costs incurred by Healthmaster, they actually saved the Medicare and Medicaid program money.

The complexity of the system, however, made it possible for fraud and abuse to take place.

- WHAT WENT WRONG

I pleaded guilty in July 1995 to ten counts of Medicare fraud. The Court found in its sentencing that the offenses to which I pleaded guilty cost the government over one million two hundred thousand dollars ($1,200,000). This loss, and more, has been repaid, and I am serving a thirty-three month sentence in federal prison. I have been in prison since November 1995.

The most significant offenses for which the Court found me financially responsible were what I will call "shared employee services," and "pleasure trips." There also were other improper practices at Healthmaster that I will describe. These offenses arise out of the potential for abuse when a company grows large in size and the ability of an outside auditor to uncover the abuses is diminished.

Let me begin with "shared employee services."

As I mentioned, with the growth of Healthmaster a complex group of businesses developed. Among these businesses, Healthmaster was the certified home health care provider. About ninety-five percent (95%) of Healthmaster's revenues came from Medicare reimbursement. For the most part, the other companies did not participate in Medicare. Despite this, I would direct employees who were paid by the Medicare reimbursed company to go work at the private companies. If the health maintenance organization needed a nurse, I would simply tell one of Healthmaster's nurses to go help out. Because the nurse continued to be paid by Healthmaster, in essence Medicare was paying for this nurse to work at one of our private companies.

When we were smaller, we kept track of this sharing of employees and would adjust Healthmaster's reimbursement requests. As we got larger the tracking process stopped. The result was that Medicare paid over $750,000 for employees who were working at non-Medicare companies.

I also was determined to be financially responsible for seeking reimbursement for pleasure trips provided to employees. Over the years Healthmaster took groups of managers on trips as a reward for good performance. We called them management meetings, but in reality they were pleasure trips. The trips were to New York City, Nashville and Las Vegas. Healthmaster paid for the airfare, hotel rooms and meals, and even gave the employees some spending money. Healthmaster then got reimbursed by Medicare for the cost of these trips. These trips cost Medicare approximately one hundred thirty-five thousand dollars ($135,000).

Another abuse at Healthmaster involved the acquisition of another home health care agency. After Healthmaster bought the agency, Healthmaster was told it could not get reimbursed for the cost of the acquisition. To get around this, Healthmaster put the four former owners on its payroll. Even though they did no work for it, these former owners each got paid eighty thousand dollars ($80,000) per year by Healthmaster. This cost the Medicare program approximately one million five hundred thousand dollars ($1,500,000).

These are just some examples of what went wrong at Healthmaster. Some of the other problems, which resulted in other former Healthmaster senior managers being convicted of Medicare fraud, are too complex to describe in this testimony. The fraud and abuse involved was made possible through the complex corporate structure that was set up. There was nothing wrong with the way the structure was set up, but it created the opportunity for massive abuse.

- POSSIBLE SOLUTIONS

  I have had a fair amount of time to think about how the Medicare program can

prevent fraud and abuse such as that which took place at Healthmaster. I hope these thoughts are of some benefit to the Committee.

First, people who become providers in the Medicare program should be required to know what is reimbursable and what is not, both before they become providers and to continue to be aware as they participate in the program. When I started out it was very simple and we were small. As we got larger and more complex, I just left reimbursement issues up to others and did not keep up with what the requirements were.

Second, senior managers of all providers should be required to certify that the cost reports submitted to Medicare are correct. Right now just one person must certify the cost reports. If all of senior management was required to put their names on the dotted line, greater internal accountability would occur. The providers would better police themselves if senior management all knew they would be accountable. For example, I do not remember signing a cost report for the last ten years or so of Healthmaster's operations.

Third, the government HCFA audit teams can be improved in at least three ways. First, it was my perception that the auditors were not always sufficiently knowledgeable about Medicare reimbursement and areas of concern to be able to identify improper reimbursement practices. Second, the audit teams seemed to change from year to year so there was no real continuity or consistency. The better the auditors understand a provider, the better they will be able to know where to look. Third, the auditors need to look not just at the home health agency itself, but at the overall structure.

As I described, the home health agency is not where an owner can make money. It is in the companies surrounding the home health agency that the big profits can be made. Audit teams need to look more closely not just at the transactions between the provider and the related party, but also at the financial activities of the related parties as an integrated business.

Finally, one of the features about Healthmaster about which I am proud is that despite all its other problems, there was never a claim that it abused the actual provision of care. I firmly believe that because we had strong local clinical management at each of our agencies, the visits we claimed were made were made. The services claimed to be rendered on a visit were rendered. The quality of the care provided was top notch. I have observed that when there is not strong local clinical management, or local clinical management at all, the potential for abuse increases. We are working with a vulnerable consumer. Requiring agencies to have local clinical management in place will help reduce the abuse on the clinical side of the program.

I hope these thoughts are of some benefit to you. I wish I were before you as something other than an example of someone who abused the system. I want to take this opportunity to apologize to you and the American people for the mistakes I made.